DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Resource Based Relative Value Scale (RBRVS) Users:
- Anesthesiologists
- Advanced Registered Nurse Practitioners
- Ophthalmologists
- Psychiatrists
- Emergency Physicians
- Nurse Anesthetists
- Physicians
- Physician Clinics
- Registered Nurse First Assistants
- Family Planning Clinics
- Federally Qualified Health Centers
- Health Departments
- Laboratories
- Managed Care Plans
- Podiatrists
- Radiologists
- Regional Administrators
- CSO Administrators

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For Information Call:
1-800-562-6188

Supersedes: 02-32 MAA
02-91 MAA
02-92 MAA

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: **Physician-Related Services: Fee Schedule Updates and Technical Changes**

Effective for dates of service on and after July 1, 2003, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2003 relative value units (RVUs);
- The updated Year 2003 Relative Value Guide base anesthesia units (BAUs);
- The updated Medicare Clinical Laboratory Fee Schedule (MCLFS);
- The Year 2003 additions of Current Procedural Terminology (CPT™) codes;
- The additions to Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes; **AND**
- The technical changes listed in this numbered memorandum.

Maximum Allowable Fees

MAA is updating the fee schedule with Year 2003 RVUs, BAUs, and clinical laboratory fees. The 2003 Washington State Legislature **has not appropriated a vendor rate increase** for the 2004 state fiscal year. The maximum allowable fees have been adjusted to reflect the updates listed above.

Below are MAA's July 1, 2003 conversion factors:

Title	Procedure Codes	July 1, 2003 Conversion Factor
Maternity	58611, 59000, 59025, 59400-59410, 59425-59426, 59430, 59510-59525, 59610-59622	$45.59
Children's Primary Health Care	99201-99215, 99431-99435, and 99381-99395	35.62
Adult Primary Health Care	99201-99215	25.00
Anesthesia		20.23
All Other Procedures Codes	Except Clinical Laboratory	22.75
Clinical Lab Multiplication Factor		0.81

Coding Changes

The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standard set of procedure codes. MAA is discontinuing state-unique codes, modifiers, and diagnoses and will require the use of applicable CPT™ and HCPCS procedure codes and ICD-9 diagnoses codes on all submitted claims. MAA is currently upgrading its claims processing system to accommodate these changes. **The state-unique procedure codes listed in this numbered memorandum will be discontinued for dates of service on and after July 1, 2003.** Any remaining state-unique procedure code that is currently used in the Physician-Related Services program will be discontinued by October 2003. MAA will notify providers of all forthcoming coding changes in a later memorandum.

Technical Changes

Clozaril Case Coordination

- **State-unique procedure code 0857J** for Clozaril Case Coordination **is discontinued**. Psychiatrists or psychiatric ARNPs must bill the appropriate CPT code for psychiatric medication management (CPT code 90862); other eligible provider types must bill using the appropriate E&M code for an office visit.

Children's Primary Health Care

- **Modifier 1C is discontinued. Use modifier HA** with CPT codes 99201-99215 to receive higher reimbursement for these services when using the parent's PIC to bill for services for an infant who has not received his or her own PIC.

Modifier HA: Child/adolescent program

EPSDT

- **Interperiodic Screens**

  State-unique procedure code 0252M is discontinued. Use the appropriate CPT Evaluation and Management (E&M) code from the range **99201-99215 with the modifier EP** to identify suspected health problems if regular screenings have already been conducted for the year.

Modifier EP: Services provided as part of Medicaid EPSDT program

  In addition, when an immunization is the only service performed, and the vaccine **is not** available free of charge from the Department of Health (DOH), the provider may bill a CPT immunization administration code in addition to the vaccine drug code. If the vaccine **is** available free of charge from DOH, bill MAA the vaccine drug code along with the modifier SL. MAA will reimburse the provider an administration fee.

☞ **Note:** When using the parent's PIC to bill E&M codes 99201-99215 for an infant who has not yet been assigned a PIC, **use modifier HA** to be reimbursed the higher rate for children's services. **Modifier HA must be the FIRST modifier following the CPT code**. Any additional modifier may be listed second.

- **EPSDT Screening for Foster Children**

  MAA will continue the higher reimbursement rate of $120.00 per EPSDT screen for foster children beyond June 30, 2003.

Family Planning

- **State-unique procedure code 1112J is discontinued.** Use the appropriate HCPCS procedure code listed in the table below:

Discontinued State-Unique Code	Replacement HCPCS Code	Brief Description	7/1/03 Maximum Allowable Fee
1112J	J3490	Unclassified Drugs (Use for Emergency Contraception Pills)	Acquisition Cost

☞ **Note:** Claims billed using the unlisted drug code J3490 must include the name of the drug given, dosage, strength, and National Drug Code (NDC) in the Comments field of the claim form in order to be reimbursed.

Injectable Drugs

- MAA will reimburse injectable drugs (other than chemotherapy drugs) at **86% Average Wholesale Price (AWP)**.
- **HCPCS code J1810** (droperidol and fentanyl citrate, 2 ml) is **no longer covered.**
- **CPT code 90378** (Synagis) **no longer requires Prior Authorization**.

☞ **Note:** Chemotherapy drug pricing remains at 95% AWP.

Identification of National Drug Codes (NDC)

- MAA is currently upgrading its claims processing system to accommodate HIPAA-compliant coding and billing changes. The upcoming HIPAA-compliant electronic claim form will have a field for reporting the NDC of any injectable drugs dispensed by the physician's office. **MAA will require this field to be completed in order to reimburse providers for injectable drugs**.

AIDS Counseling Services

- **State-unique code 9020M** for HIV counseling services **is discontinued.** Use the CPT replacement code listed in the table below.

Discontinued State-Unique Code	Description	Replacement CPT Code	Brief Description
9020M	Risk factor reduction intervention for HIV/AIDS clients	99401	Preventive counseling, indiv ***Reimbursement is limited to ICD-9 diagnosis V65.44***

Involuntary Treatment Act (ITA)

- **The following state-unique codes** for ITA services **are discontinued**. Use the HCPCS replacement codes listed in the table below.

Discontinued State-Unique Code	Description	Replacement HCPCS Code	Brief Description
9083M	ITA physical exam	*This code is discontinued. There is no assigned replacement code for this activity.*	
9084M	ITA psychiatric admission and evaluation	90801	Psy dx interview
9085M	ITA court testimony, under 20 minutes	99075	Medical testimony • *1 unit = 10 minutes* • *Max. of 5 units allowed*
9086M	ITA court testimony, 20-50 minutes		
9087M	ITA court testimony, over 50 minutes		

Radiology Services

- State-unique **modifier 1R is discontinued**. Providers must bill the CPT code for the radiology exam performed with a **modifier 26** to indicate a professional consultation on the x-ray only.

- State-unique **codes 7612M and 7698M** for transportation and set-up for portable x-ray equipment **are discontinued**. There are no assigned replacement codes for these activities. Use the appropriate CPT or HCPCS codes to bill for these services.

Tuberculosis Treatment Services

- **State-unique codes 9011M and 9012M** for tuberculosis treatment services **are discontinued**. Use the appropriate E&M codes to bill for these services.

Developmental Disabilities Program

- **State-unique code 0310M** for an annual physical exam as part of the Developmental Disabilities program **is discontinued**. In addition, **state-unique diagnosis code V93.0 may no longer be used**. Use HCPCS code T1023 with modifier HI and an ICD-9 diagnosis from the range V79.3–V79.9 to bill for an annual exam. **Claims without one of these diagnoses for this client population will be denied**.

Modifier HI: Integrated mental health and mental retardation/developmental disabilities program

Detox Services

- **State-unique procedure codes 0025M and 0026M** for detox physician care admission and follow-up **are discontinued**. There are no assigned replacement codes for these activities. Use the appropriate CPT code(s) to describe the services performed.

Casting Materials

- **State-unique procedure codes 2978M–2987M** for casting materials **are discontinued.** Use the appropriate HCPCS codes from the range Q4001-Q4049 when billing for casts. All fees are determined by Medicare's pricing and are contained in the attached fee schedule.

Cardiography

- **State-unique procedure codes 9301M, 9302M, and 9303M** for cardiography **are discontinued**. There are no assigned replacement codes for these activities. Use the appropriate CPT or HCPCS codes to describe the services performed.

Neurology

- **State-unique procedure codes 9593M and 9254M** for vestibular function testing and electronystamographic testing **are discontinued**. There are no assigned replacement codes for these activities. Use the appropriate CPT or HCPCS codes to describe the services performed.

Ophthalmology

- **The following state-unique codes** for ophthalmology services **are discontinued**. Use the appropriate CPT code(s) listed in the table below:

Discontinued State-Unique Code	Description	Replacement CPT Code	Brief Description
9274M	Materials used for glasses repair	92390	Supply of spectacles
9275M	Fitting (incl. dispensing) fee for therapeutic bandage lenses (incl. 14 day follow-up)	92070	Fitting of contact lens *New code does not include any follow-up days*
9276M	Fitting (inc. dispensing) of contact lenses (incl. 30 day follow-up)	92310-92313	Contact lens fitting *New code does not include any follow-up days*
9277M	Fitting of contact lenses for treatment of disease	*This code is discontinued. There is no assigned replacement code for this activity*	

Surgery

- **State-unique code 4693M** for infrared coagulation of internal hemorrhoids **is discontinued**. There is no assigned replacement code for this activity. Use the appropriate CPT or HCPCS codes to describe the services performed.

- **CPT code 58350** for chromotubation of oviduct **is no longer covered**.

Psychiatry

- **The following state-unique codes** for psychiatric services **are discontinued**. Use the CPT code listed in the table below.

Discontinued State-Unique Code	Description	Replacement CPT Code	Brief Description
0070M	Psychological evaluation (testing included)	96100	Psychological testing *See limitations below.*
9089M	Certification activities related to elective inpatient psychiatric admission for clients less than 21 years of age to an inpatient psychiatric facility.	*This code is discontinued. There is no assigned replacement code for this activity.*	

- **Billing for Psychological Evaluations**

  MAA will reimburse for psychological evaluations using CPT code 96100. Up to two (2) units of CPT code 96100 are allowed without prior authorization per client, per lifetime.

  If additional testing is necessary, psychologists must request additional units of CPT code 96100 through the prior authorization process as detailed in MAA's Physician-Related Services Billing Instructions in Section I: Authorization.

Trauma

- **Modifier 9T is discontinued. Use modifier ST** with the appropriate CPT or HCPCS codes in order to receive higher reimbursement for services provided as part of the trauma program. Additional payment is subject to MAA's current guidelines and legislative funding for the trauma program.

Modifier ST: Related to trauma or injury

Implants

- **State-unique procedure code 1949M** for tissue expander implant **is discontinued.** There is no assigned replacement code for this device. Use the appropriate HCPCS code(s) to bill for the device used.

Maternity Services

- **Discontinued Maternity Codes**

  The following state-unique maternity codes are discontinued. See page 11 and 12 of this numbered memorandum for the appropriate replacement codes/modifiers.

Discontinued State-Unique Code	Description
5930M	Initial prenatal assessment
5935M	Labor management
5941M	High-risk vaginal delivery add-on fee
5947M	Antepartum and postpartum care and assist at cesarean section
5951M	Routine antepartum care, first and second trimester, per month
5952M	Routine antepartum care, third trimester, per month
5953M	High-risk management, first trimester, add-on
5954M	High-risk management, second trimester, add-on
5955M	High-risk management, third trimester, add-on
5959M	High-risk cesarean section, add-on fee

- **Billing for Maternity Services Using CPT and HCPCS Codes**

  Per CPT guidelines, MAA considers routine antepartum care for a normal, uncomplicated pregnancy to consist of monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery.

  Providers who provide **increased monitoring** for high-risk conditions in excess of the CPT guidelines for normal antepartum visits may bill using evaluation and management (E&M) **codes 99211-99215**. Provides must include a valid high-risk pregnancy diagnosis in order to receive additional reimbursement outside of the global antepartum care. The office visits may be billed in addition to the global fee **only after** exceeding the CPT guidelines for normal antepartum care.

  In addition, MAA will continue to reimburse providers for one prenatal assessment per provider, per client, per pregnancy.

Delivery includes management of uncomplicated labor and vaginal delivery (with or without episiotomy, with or without forceps) or cesarean section. If a complication occurs during delivery resulting in an unusually complicated, high-risk delivery, the provider may receive additional reimbursement for the procedure by **adding modifier TG to the delivery code** (e.g. 59400 TG or 59409 TG). MAA will make an enhanced payment above the normal delivery reimbursement rate. The specified diagnosis code must demonstrate the medical necessity for high-risk delivery add-on.

Modifier TG: Complex/high level of care

If the provider cares for the client during labor, but transfers care of the patient to another provider for the delivery, the provider may bill for his or her time spent managing the client's labor using the appropriate E&M codes, including prolonged services codes.

Postpartum care includes any office or home visits following delivery, including the six-week postpartum check-up.

If a provider performs all or part of the antepartum care and/or postpartum care but does not perform the delivery, he or she must bill MAA for only those services provided using the appropriate antepartum and postpartum care codes. **In addition, if the client obtains other medical insurance coverage or is transferred to an MAA managed care plan during her pregnancy, the provider must bill MAA for only those services provided while the client is enrolled with MAA fee-for-service.**

In some circumstances, MAA will require the use of **modifier TH** in order to process payment for an E&M code with a normal pregnancy diagnosis (see table on next page).

Modifier TH: Obstetrical treatment/services, prenatal or postpartum

The standardized CPT and HCPCS codes listed in the tables on the following pages replace the discontinued state-unique procedure codes. Please refer to the current CPT and HCPCS books for complete descriptions of these procedure codes.

Normal Antepartum Care

Discontinued Code	Replacement Procedure Code/ Modifier	Summary of Description	Limits
5930M	T1001 TH	Nursing assessment, w/obstetrical service modifier	Limited to one unit per client, per pregnancy, per provider. Must use modifier TH to be reimbursed.
5951M 5952M	99211-99215 TH	Office visits, antepartum care 1-3 visits only, w/obstetrical service modifier	Diagnoses V22.0–V23.9 limited to 3 units; must use modifier TH with these diagnoses to be reimbursed.
	59425	Antepartum care, 4-6 visits	Limited to one unit per client, per pregnancy, per provider
	59426	Antepartum care, 7+ visits	Limited to one unit per client, per pregnancy, per provider

☞ **Note:** Do not bill CPT codes 59425, 59426, or E&M codes 99211-99215 with normal pregnancy diagnoses in combination during the same pregnancy. **Do not bill MAA for antepartum care until all antepartum services are complete.**

Additional Monitoring for High-Risk Conditions

Discontinued Code	Replacement Procedure Codes	Summary of Description	Limits
5953M 5954M 5955M	99211-99215	Office visits; use for increased antepartum care due to high-risk conditions	May not be billed with a normal pregnancy diagnosis (V22.0-V23.9); diagnosis must detail need for additional visits.

Prenatal/Postpartum Care and Assist at C-Section

Discontinued Code	Replacement Procedure Code	Summary of Description	Limits
5947M	*Unbundle the global maternity codes and bill for those services provided. The assist at C-section must be billed as 59514 with modifier 80.*		

Labor Management

State-unique code 5935M is discontinued. Use the appropriate CPT codes listed in the table below. When billing for prolonged services, bill the appropriate prolonged services procedure code on the same claim form as the E&M code along with modifier TH and one of the diagnoses listed below on each detail line of the claim form.

Discontinued Code	Replacement Procedure Code/ Modifier	Summary of Description	Limits
5935M	99211-99215 TH	Office visits – labor at home or provider's office	Diagnoses 640–674.9; V22.0–V22.2; and V23–V23.9; must have modifier TH to pay with normal pregnancy diagnoses; **may not be billed by delivering physician.**
	+ 99354 TH **Limited to 1 unit**	Prolonged services, 1st hour	
	+ 99355 TH **Limited to 4 units**	Prolonged services, each add'l 30 minutes	
	99251–99255 TH; 99261–99263 TH	Hospital E&M services - Labor management fee; inpatient hospital setting	
	+99356 TH **Limited to 1 unit**	Prolonged services, inpatient setting, 1st hour	
	+99357 TH **Limited to 4 units**	Prolonged services, inpatient setting, each add'l 30 minutes	

+ = Add-on Code

High-Risk Delivery Add-On

MAA will pay a flat fee of $282.81 in addition to the reimbursement amount for the delivery itself. Use modifier TG with the actual delivery code performed (e.g. 59400 TG or 59409 TG).

Discontinued Code	Replacement Procedure Code/ Modifier	Summary of Description	Limits
	TG added to delivery code	Complex/high level of care	Diagnosis code must demonstrate the medical necessity for high-risk delivery add-on.
5959M	TG added to delivery code	Complex/high level of care	

Summary of Crossed State-Unique Procedure Codes

Attached is a summary of state-unique procedure codes that are discontinued for claims with dates of service after June 30, 2003 and their appropriate replacement (if applicable). This table is for informational purposes only and does not contain applicable policies, limitations, or reimbursement rates.

Discontinued State-Unique Code	Replacement Procedure Code/ Modifier	Discontinued State-Unique Code	Replacement Procedure Code/ Modifier
0310M	T1023 HI	5930M	T1001 TH
0025M	None	5941M	modifier TG
0026M	None	5935M	99211-99215, plus +99354, +99355 modifier TH or 99251-99255, 99261-99263 plus +99356, +99357 modifier TH
9020M	99401		
1112J	J3490	5947M	Unbundle global codes
0252M	99201–99215 EP		
0857J	90862; 99201-99215	5951M	99211-99215 TH; 59425; **or** 59426
2978M	Q4001–Q4049	5952M	
2979M	Q4001–Q4049	5953M	99211–99215
2980M	Q4001–Q4049	5954M	99211–99215
2981M	Q4001–Q4049	5955M	99211–99215
2982M	Q4001–Q4049	5959M	modifier TG
2983M	Q4001–Q4049	7612M	None
2984M	Q4001–Q4049	7698M	None
2985M	Q4001–Q4049	4693M	None
2986M	Q4001–Q4049	9089M	None
2987M	Q4001–Q4049	0070M	96100
9083M	None	9274M	92390
9084M	90801	9275M	92070
9085M	99075	9276M	92310-92313
9086M	99075	9277M	None
9087M	99075	9593M	None
9301M	None	9254M	None
9302M	None	9011M	99201–99215
9303M	None	9012M	99201–99215
1949M	None		

Physician-Related Services Billing Instructions

MAA is currently updating the Physician-Related Services Billing Instructions. The entire fee schedule can be viewed online at MAA's website at http://maa.dshs.wa.gov (click on Provider Publications/Fee Schedules link).

Bill MAA your usual and customary charge.